STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155319	B. WING		03/28/2012		
NAME OF I	DROVADED OD GLIDDI IE		STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	EK	375 S	11TH ST			
CLINTO	N GARDENS		CLINTON, IN 47842				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0000							
F0000	This visit was State Licensul included the Ir Complaints IN IN00104612. Complaint #IN00104612- lack of evident Complaint #IN00105028- Federal/state the allegation F353. Survey dates:	for a Recertification and re Survey. This visit hyestigation of 100105028 and -Unsubstantiated due to ce. -Substantiated. deficiencies related to are cited at F315 and 21-23, 26-28, 2012 er: 000212 ber: 155319 100285040 ar, RN, TC RN , RN r, RN, TCRN r, RN, TCRN r, RN, TCRN	F0000	The creation and submission of the of Correction does not constitute ar admission by this provider of any conclusion set forth in the statemer deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter Credible Allegation and requests a Certification Review on or after Apr 2012.	Plan of of Post		
	Total: 76						
1	1						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PRINTED: 04/24/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		155319	A. BUI B. WIN	LDING		03/28/	
NA 55 05 5	AD OUTDOOR OF SUPPLY		P. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			375 S 1	1TH ST		
CLINTON	N GARDENS			CLINTC	N, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	Census payor t			mo	·		DATE
	Medicare: 15	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Medicaid: 46						
	Other: 15						
	Total: 76						
	There define	-i					
		cies reflect state n accordance with 410					
	IAC 16.2.	raccordance with 410					
	Quality review	completed on April 4,					
	2012 by Bev Fa	aulkner, R.N.					

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C			ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155319	B. WIN			03/28/	2012
			D. 1111	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				1TH ST		
CLINTON	N GARDENS				DN, IN 47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241 SS=D	A83.15(a) DIGNITY AND R INDIVIDUALITY The facility must in a manner and maintains or enh and respect in fu individuality. Based on obse record review, fassist residents prevent inconting residents review sample of 3 wh dignity. [Resident Findings includ 1. On 3/16/12 a Resident G was call light turned answered the of light off and incompanies she would get of The nurse indicated she indicated she in toilet. At 11:43 the room and a	promote care for residents in an environment that ances each resident's dignity II recognition of his or her rvation, interview, and the facility failed to a in a timely manner to nence for 2 of 3 wed for dignity in the to met the criteria for ents G and B] e: at 11:00 a.m., s observed to have her on. LPN #7 call light, turned the dicated to the resident CNA #1 to help her. Cated one of the CNAs a unit was on lunch and dents get backed up 11:15 a.m., the terviewed. The call light on and deeded assistance to a.m., CNA #2 entered sked the resident what	F02		Dignity and Respect of Individuality. It is the practice this facility to promote care for residents in a manner and in a environment that maintains or enhances each resident's dign and respect in full recognition his or her individuality. What corrective actions will be accomplished for those reside found to have been affected by the deficient practice? *An inservice was held by the DNS 04/12/12 and 04/17/12 for all direct care staff to educate regarding provisions of providi resident assistance in a timely manner to prevent incontinent and maintain or enhance digni and respect. *CNA's were observed by the DNS in provict timely incontinence care to residents B & G. Any staff that demonstrated deficient practic in protocol were redirected to acceptable practice and requir to give a return demonstration demonstrate competency in sk and techniques as it relates to efficient incontinence care. *Residents B & G call lights ar being answered timely and call	of n ity of nts y s on ng ne ty ling es ed to kills	DATE 04/27/2012
	indicated she n toilet. At 11:43 the room and a	eeded assistance to a.m., CNA #2 entered			and techniques as it relates to efficient incontinence care. *Residents B & G call lights ar	e re	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155319			03/28/2012	
			B. WING	EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R				
CLINITON	LOADDENIC			S S 11TH ST		
CLINTOR	N GARDENS		CL	INTON, IN 47842		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREF		E COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAC	G DEFICIENCY)	DATE	
ı	and CNA #2 ex	xited the room. CNA		an observation of a 3 day vo		
	#1 entered the	room right after CNA		pattern to determine their ty	•	
	#2 had exited	and started to take the		voiding schedules. Results		
		wheelchair to the		updated in the resident care		
		At this time, CNA #1		and the CNA pocket tools for notification of any changes	l l	
	_	the resident needed to		consistency of care. How w		
				identify other residents havi	· .	
		om. CNA #1 indicated		potential to be affected by the		
		e to get another CNA		same deficient practice and		
		d exited the room. CNA		corrective action will be take	en?	
	#2 returned an	d indicated to the		*All dependent residents ha	ve the	
	resident she w	ould return as soon as		potential to be affected. *All		
	she was done	delivering condiments		dependent residents will be		
		nts on the unit having		reassessed for voiding patte		
	lunch in their re	_		using the Bladder Assessme including a 3 day voiding pa		
		001113.		assessment. Any resident	uem	
	On 2/46/42 at	11:45 a m CNA a #1		admitted to the facility will be	<u> </u>	
		11:45 a.m., CNAs #1		assessed upon admission.		
		d to the resident's		inservice was held by the D	l l	
		echanical lift. The		04/12/12 and 04/17/12 for a	l l	
	resident was tr	ransferred to the bed,		direct care staff to educate		
	placed on a be	edpan and was		regarding resident assistant		
	observed to ha	ave been incontinent of		timely manner to prevent an		
	bowel.			manage incontinence. Wha		
				measure will be put into place	l l	
	During the inte	rview of the resident on		what systemic changes will make to ensure that the def	· I	
		15 a.m., the resident		practice does not recur? *T		
		-		DNS/Designee shall perform		
		etimes she has to wait		random audits/facility round	l l	
	over an hour a			X3 shifts to monitor resident	-	
		n toileting. The resident		incontinence and timeliness	of	
	indicated they	needed more help and		care using CNA Proficiency		
	indicated she l	knew she has been on		Standards. *Residents will	be	
	the call light to	o much at times.		interviewed using the CQI	,	
				Resident Care Rounds Tool	l l	
	Resident G's o	linical record was		ensure compliance. *Staff for not to respond to call lights	puriu	
		/26/12 at 1:41 p.m. The		promptly and/or not provide	care	
		•		promptly will be addressed	ouro	
	iviinimum Data	Set [MDS] with	1	promptly will be addressed		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155319	B. WIN			03/28/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			1TH ST		
CLINTON	N GARDENS				DN, IN 47842		
					71, 11 17 012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	assessment re	ference date of			immediately. *All employees		
	1/10/12, coded	the resident with			are educated on dignity and		
	moderate cogr	itive impairment., no			respect upon hire. How the corrective actions will be		
	_	and as frequently			monitored to ensure the deficient	ant	
		powel (2 or more			practice will not recur, i.e., wha		
		at least one continent			quality assurance program will		
	l •				put into place? *The		
	' '	ladder (7 or more			DNS/Designee will audit the		
	· ·	nary incontinence but			timeliness of call light respons	е	
	•	isode of continent			for a minimum of 5 staff memb		
	voiding).				daily, to include all shifts, for th	ne	
					next 30 days. Any		
	The Resident (Care Sheet, dated			non-compliance will be		
	3/27/12. includ	ed, but was not limited			immediately corrected. *To		
		chanical lift with			ensure compliance, the DNS/Designee is responsible	for	
		wo for transfers. Assist			the completion of Resident Ca		
					Rounds CQI tool weekly times		
		ities of daily living,			weeks, bi-monthly time 2 month		
		m of T-time [i.e. upon			and then quarterly until continu		
	_	nd after meals, at hour			compliance is manitained for 2	2	
	of sleep and pr	n] and pull ups.			consecutive quarters. The res		
					of these audits will be reviewe		
					by the CQI committee oversee		
					by the ED. If threshold of 95%		
					not achieved an action plan wi	II	
					be developed to ensure compliance including possible		
					disciplinary action up to		
					termination.		
	2 02 2/45/40	at 2:20 n m . Danidant					
		at 2:30 p.m., Resident					
	_	a wheelchair on the E					
	1	CNA #3 was picking up					
	water pitchers.	The resident indicated					
	to CNA #3 "Ple	ease, I've got to go to					
		A #3 indicated "Just a					
		CNA kept picking up					
	water pitchers.	THE TESIUEHL					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319		LDING	NSTRUCTION 00	(X3) DATE COMPI 03/28/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
	now." At 2:40 p the resident to was not presen indicated, "I told to the bathroon me, now I ' m w pants were obs p.m., CNAs #1 standing at a d work, talking at 2:50 p.m., RN # Resident B bac indicated to CN wet and needs 2:55 p.m., CNA Resident B to t The resident ga observation of right as long as #3 asked the re wrong?" The re pants, I hate th heavy urine od room. A facility policy Rights," dated or received from t 3 p.m. Docume under the head	d them I wanted to go n and they didn't take wet. The resident's served wet. At 2:45 and #3 were on E unit esk looking at paper pout assignments. At #5 was pushing sk to the unit. The RN IAs # 1 and #3 "She's to be cleaned up." At as #1 and #3 took the resident's room. The exident "Are you ok?" as you ok?						

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	OF CORRECTION II	1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 155319		LDING	00	CO	MPLETED MP28/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL CONTROL OF THE SECTION OF THE S		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE		
	with and access	nd communication to persons and nd outside the facility							
	3.1-3(t)								

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155319	B. WING	1110		03/28/	2012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER	R		375 S 1			
CLINTO	N GARDENS				N, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		REFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
F0242 SS=E	483.15(b) SELF-DETERMI	NATION - RIGHT TO MAKE					
	CHOICES						
		s the right to choose					
	· ·	ules, and health care					
		nis or her interests,					
		nd plans of care; interact with community both inside and					
		ty; and make choices about					
		her life in the facility that are					
	significant to the						
	Based on reco	ord review and	F0242	2	Self-Determination- Right to		04/27/2012
	interview, the fa	acility failed to ensure			Make Choices. It is the practic		
		able to choose their			this facility to allow residents to		
		e for 2 of 3 residents			have the right to choose activity schedules and health care	ties,	
	1	d H) interviewed from			consistent with his or her		
	,	3 who met the criteria			interests, assessments, and pl	lan	
	•				of care. What corrective action		
		is potentially affected 8			will be accomplished for those		
		each of 3 of 3 units in			residents found to have been		
	_	total of 24 residents			affected by the deficient practi	ce?	
	1	tance of one or two			*Residents D and H were		
	with dressing.				reinterviewed by the Activity Director for their choice of		
					morning routine schedule, usir	ng	
	Findings includ	e:			the Preferences for Daily		
					Customary Routines form.		
					Resident responses were place on the CNA pocket tool and ca		
	1	view of Resident D on			plans were updated. *Residen		
		a.m., the resident			D and H are now getting up pe		
		s woken up at 4:30			their choice. How will you iden		
	a.m. to be bath	ed and dressed. The			other residents having the	-	
	resident indicat	ted, "I've told them			potential to be affected by the		
	[CNAs] but the	y don't pay attention.			same deficient practice and who		
	This morning th	ney got me up at 4:45					
	a.m., and dress	sed me. They would let					
		own, but who wants to			reassessed for choices of	-	
		-	ı				1
	lay back down	after that? They get			morning routines using the Preferences for Daily Customa		
	a.m., and dress	sed me. They would let own, but who wants to				al to	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	I DINC	_G 00		COMPLETED	
		155319		LDING		03/28/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹						
CLINITO	I CADDENIC				1TH ST			
CLINTO	N GARDENS			CLINIC	DN, IN 47842			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	but I go to bed	earlier because I			Routines form. Resident			
	wouldn't get er	ough sleep. I've told			responses will be placed on th			
	_	't want to get up that			CNA pocket tool and care plar	ıs		
		say they have so many			will be updated. Any resident			
	1 ,	ve to get dressed."			admitted to the facility will be assessed upon admission. W	hat		
	l beoble illey ha	ve to get dressed.			measures will be put into place			
	D : 1 : 51 : 5				for what systemic changes you			
		linical record was			will make to ensure that the	-		
	reviewed on 3/	26/12 at 3:30 p.m.			deficient practice does no recu	ır?		
					*All newly admitted residents v			
	A significant ch	nange [MDS] Minimum			be assessed for choices of			
	Data Set asses	ssment, dated 1/22/12,			morning routines using			
		dent with moderate			the Preferences for			
	cognitive impai				Daily Customary Routines forr			
		oded the resident as			by the Activity Department as	part		
					of their normal admission	_1		
		sive assistance with			assessment process. Resider responses will be placed on the			
		oileting and extensive			CNA pocket tool and care plan			
	assistance of c	one for dressing and			will be updated. *Nursing staff			
	hygiene.				have been reeducated related			
					allow residents to have the rigi			
					to choose activities, schedules	3		
	During intervie	w of CNA # 1 on			and healthcare consistent with	his		
	_	m., the CNA indicated			or her interests, assessments,			
		s supposed to have			and plan of care. Specifically			
	_	esidents up and			regarding choice of morning			
		•			routine. *Resident choices are placed in the ADL book.			
		the day shift comes in			Licensed nurse will monitor the	<u> </u>		
		CNA indicated Resident			ADL book daily to	-		
		when the CNA came			ensure residents' choices are			
	in at 6 a.m., but	it was laying back down			being met. How the corrective	;		
	this morning.				action will be monitored to ens	ure		
					the deficient practice will not			
					recur, i.e., what quality assura			
	During intervie	w of the ADON			program will be put into place?	•		
	_	ctor of Nursing) on			*To ensure compliance, the	£		
	1 · ·				DNS/Designee is responsible	ΙΟΓ		
		a.m., the ADON			the completion of Resident Care Rounds CQI tool weekly			
	indicated each	unit is expected to			Care Rounus CQI tool weekly			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE S COMPL		
ANDILAN	or connection	155319	1	LDING	00	03/28/	
		100010	B. WIN		ADDRESS CITY STATE TIP CODE	00/20/	2012
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE 1TH ST		
CLINTON	N GARDENS				DN, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		ight residents up. We		IAG	times 4 weeks, bi-monthly time	29	DATE
		hich residents they			2 months, and then quarterly t		
	have to get up.	•			continued compliance is		
	navo to got up.				maintained for 2 consecutive quarters. The results of these		
					audits will be reviewed by the		
					committee overseen by the EI		
					If a threshold of 95% is not		
					achieved an action plan will be developed to ensure complian		
					including possible disciplinary		
					action up to termination.		
	_	riew of Resident H on					
		p.m., the resident					
	_	ets up between 4 a.m.					
		The resident indicated					
		oice she would get up					
		esident also indicated					
		't force her to get up, ncourage her. The					
	resident stated	_					
	assistance to g	·					
		op.					
	Review of the	clinical record of					
	Resident H on	3/27/12 at 2 p.m.,					
	indicated the m	ost recent Minimum					
	•	s) assessment was					
		6/12. The assessment					
		esident with moderate					
	-	cognitive decision					
	making skills, a						
		transfers, dressing,					
	eating, hygiene	;, and balining.					
	Interview of CN	IA #10 on 3/28/12 at					
	12:05 p.m., ind	icated the night shift					
	was supposed	to be getting 8					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155319	A. BUI	LDING	00	COMPLE 03/28/2	
		100018	B. WIN		PPPPG GWY GW	03/26/2	2012
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE 1TH ST		
CLINTON	N GARDENS				DN, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		sed and up on each		TAG			DATE
		come in on day shift.					
	diffic before we	come in on day smit.					
	Interview of RN	N #5 on 3/27/12 at					
		licated the night shift					
		eight residents up					
	-	ft and that they usually					
		residents up between					
	4-5 a.m.						
		titled "Resident					
	_	January 2006, was the DON on 3/28/12 at					
		entation indicated					
	•	ding of "Quality of Life"					
		nt had the right to make					
		aspects of his or her					
		y that are significant to					
	the resident.	,					
	3.1-3(u)(1)						

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Facility ID: 000212

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155319	B. WING		03/28/2012
			_	ET ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
OLINITON	LOADDENO			S 11TH ST	
CLINTON	N GARDENS		CLIN	NTON, IN 47842	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0280 SS=A	483.20(d)(3), 483 RIGHT TO PAR	3.10(k)(2) TICIPATE PLANNING			
	CARE-REVISE (
	incompetent or o incapacitated un	the right, unless adjudged otherwise found to be der the laws of the State, to nning care and treatment or and treatment.			
	developed within of the compreher by an interdiscipl attending physici responsibility for appropriate staff by the resident's practicable, the pattern than the resident's far representative; a	e care plan must be a 7 days after the completion ansive assessment; prepared linary team, that includes the aian, a registered nurse with the resident, and other in disciplines as determined needs, and, to the extent coarticipation of the resident, mily or the resident's legal and periodically reviewed and of qualified persons after of t.			
	review, the faci 3 resident's fan interviewed reg conferences. [F Finding include On 3/21/12 at 1 #69's family reginterviewed. The indicated he was representative who would be rein condition or in the statement of the statement	parding care plan Resident #69] In the state of the stat	F0280	Right to Participate Planning Care- Revise CP It is the prace of this facility to notify and reviplans of care as prepared by a interdisciplinary team to include the participation of the resident the resident's family or the resident's legal representative What corrective actions will be accomplished for those reside found to have been affected b the deficient practice? *The fa representative has been contacted regarding the care p conference for resident #69 at scheduled on 04/12/12 at 1:00 p.m. Although an official mee was scheduled on this date, n that the family representative the facility almost daily and ha	iew an de it, e ents y mily blan nd) ting ote is at

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Event ID: 8WKN11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLI	ETED
		155319				03/28/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
OLINITON	LOADDENIO				1TH ST		
CLINTON	N GARDENS			CLINIC	DN, IN 47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	member indica	ted he had not been			open communication with the		
	made aware of	the conferences in the			licensed nurse, CNA's and		
	last couple of y				administration. How will you		
	last souple of y	odio.			identify other residents having	the	
	Desident #60's				potential to be affected by the		
		clinical record was			same deficient practice and wl		
		27/12 at 10:49 a.m.			*All residents have the potential		
		Data Set [MDS]			be affected. *Social Service	ai to	
	assessment wi	th reference date of			Designee and MDS Coordinat	or I	
	9/6/11 coded th	ne resident with severe			will schedule care plan		
	cognitive impai	irment. A form titled			conferences for each resident		
	"Interdisciplina	ry Care Plan			quarterly, annually, significant		
	•	g," provided by the			change and/or as requested b	y	
		Director on 3/27/12 at			resident/resident family. The		
					interdisciplinary team will be		
	I	uded, but was not			provided a monthly schedule a		
		imentation of persons			updates as needed. Care plan		
	_	esident's care plan			scheduling will coordinate with MDS process. What measure		
	conferences. T	he most recent			will be put into place or what	°	
	conference dat	te was noted of 2/6/12.			systemic changes you will mal	ke	
	The most recei	nt documentation of			to ensure that the deficient		
	family attendar	nce was noted of			practice does not recur?* The		
	2/24/11.				care plan conference schedule	•	
					will collaborate with the MDS		
	The SSD was i	interviewed on 3/27/12			process schedule. Social		
					Services will mail an invitation		
	•	he SSD indicated she			post card to family members a	nd	
		um Data Set [MDS]			obtain a copy in the care plan schedule binder. How the		
		ere the persons			corrective actions will be		
	responsible for	notifications to			monitored to ensure the deficie	_{ent}	
	resident/family	regarding care plan			practice will not recur, ie., wha		
	_	SSD indicated the			quality assurance program will		
		ave gone by the			put into place?*The MDS		
	1 -	th staff had extended			Coordinator will audit care pla		
	,	to medical reasons.			conference participation at lea	st	
					quarterly to ensure review of		
		ated the system had			plans of care are held with the		
		ted. The SSD indicated			participation of the resident, the		
	If documentation	on of family was lacking			resident's family or the resider	ii S	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155319	B. WIN	IG		03/28/	2012
NAMEGER	DOLUDED OF GURDLES	`		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	(375 S 1	1TH ST		
CLINTON	N GARDENS			CLINTO	N, IN 47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on the care pla	n meeting form they			legal representative. Any		
	may not have b	peen notified. The SSD			non-compliance will be		
		mentation of resident			immediately corrected.*To en		
		sentatives notifications			compliance, the MDS Coordin		
		d not previously been			and Social Service Designee in responsible for the completion		
	maintained.	a not providuoly boom			the Care Plan Review CQI To		
	mamiamicu.				weekly times 4 weeks, bi-mon		
	A facility policy	titled "Core Plan			times 2 month, and then quart	•	
	, , ,	titled "Care Plan			until continued compliance is		
		aintenance Process,"			maintained for 2 consecutive		
		ate of 8/2/11 provided			quarters. The results of these		
		3/27/12 at 1:50 p.m.,			audits will be reviewed by the committee overseen by the El		
	included, but n	ot limited to, "Resident,			a threshold of 95% is not	J. II	
	resident's famil	lies or others as			achieved, an action plan will b	е	
	designated by	resident will be invited			developed.		
	to care plan rev	view."			•		
	•						
	3.1-35(c)(2)(C)	1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155319	B. WIN			03/28/	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				1TH ST		
CLINTON	N GARDENS				DN, IN 47842		
			1		T	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	DATE
F0312		LSC IDENTIFTING INFORMATION)		TAG			DATE
SS=D	483.25(a)(3)	VIDED FOR DEPENDENT					
33-0	RESIDENTS	WIDED I ON DEI ENDENT					
		s unable to carry out activities					
		eives the necessary services					
		nutrition, grooming, and					
	personal and ora	al hygiene.					
	Based on obse	rvation, interview and	F03	12	ADL Care Provided for		04/27/2012
	record review, t	the facility failed to			Dependent Residents. It is the		
	· ·	al hygiene for 2 of 4			practice of this facility to carry		
		ndent for incontinence			activities of daily living necessate to maintain good nutrition,	ary	
		in that skin was not			grooming, and personal and or	ral	
	· · · · · · · · · · · · · · · · · · ·	insed after being			hygiene. What corrective action		
		•			will be accomplished for those		
		ırine. [Resident #71			residents found to have been		
	and Resident B	9]			affected by the deficient praction	ce?	
	l <u>_</u>				*CNA's were observed by the		
	Findings includ	e:			DNS for providing proper	1_	
					personal hygiene for Resident' #71 and B. Any staff that	S	
	1. On 3/22/12	•			demonstrated deficient practic	es	
	Resident #71 w	vas observed to be			in protocol were redirected to		
	incontinent of u	rine. A strong urine			acceptable practice and requir	ed	
	odor was noted	I in the resident's			to give a return demonstration	to	
	room. CNAs #1	and #11 were			demonstrate competency in sk		
	observed to lift	Resident #71 with the			and techniques as it relates to		
	stand up mecha	anical lift. The resident			efficient incontinence care and		
	was observed t				personal hygiene. *Nursing state have been reeducated by the	111	
		rine and her slacks			DNS on 04/12/12 and 04/17/12	2	
		t from the knees to the			related to proper personal		
	weie visibly we waist band. Th				hygiene provided to residents	for	
					incontinence care and thoroug	-	
		ed. The resident's			cleansing of the skin from uring	e.	
		urated incontinence			How will you identify other	to	
		oved. The CNAs			residents having the potential to be affected by the same deficient		
	l ·	are. The back of the			practice and what corrective	CIIL	
		that had been in			action will be taken? *All		
	contact with the	e resident's wet slacks			incontinent residents have the		
	were observed	not to have been			potential to be affected. *The		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIM DD	NG	00	COMPLI	ETED
		155319	A. BUILDIN	NG		03/28/2	2012
			B. WING	TDEET	DDDESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
01.11.17.01					1TH ST		
CLINTON	N GARDENS		10	CINIO	N, IN 47842		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)	' ⁻	DATE
	cleansed.				DNS/Designee shall perform		
	G.Gar.iggar.				random audits/facility rounds t	o	
	Dee: de 104 #741	aliniaal na sanalaa			monitor resident incontinence		
		s clinical record was			proper personal hygiene		
	reviewed on 3/	27/12 at 4:28 p.m. The			standards. Resident's will also	be	
	resident's diag	noses included, but			interviewed using the CQI		
	was not limited	I to Alzheimer's			Resident Care Rounds Tool to		
ı		entia, and kidney			ensure compliance. *Nursing s		
	disease.	aria marioy			have been reeducated related	to	
	uiscasc.				proper personal hygiene to		
					residents for incontinence care		
		Data Set [MDS]			and thoroughly cleansing of th		
	assessment w	ith assessment			skin from urine by the DNS on		
	reference date	of 2/3/12, coded the			04/12/12 and 04/17/12. What		
		evere cognitive			measures will be put into place		
		on-ambulatory, required			what systemic changes you w		
	· ·				make to ensure that the deficie	ent	
		stance of two for bed			practice does not recur? *All		
	mobility and tra	ansfers, total			CNA's will perform a skills	for	
	assistance of o	one for dressing,			validation in proper technique		
	extensive assis	stance of two for toilet			providing incontinence care by SDC/designee by 04/27/2012.		
	use and freque	ently incontinent of			Any process of personal hygie		
	bowel and blace	-			that is noncompliant will be	ii C	
	DOWEL ALIG DIAG	idei.			immediately redirected. *An		
					inservice held by the DNS on		
		dated 10/27/11,			04/12/12 and 04/17/12 for all		
	addressed the	problem of potential			direct care staff to educate sta	ıff	
	for skin breakd	lown related to fragile			regarding proper personal		
		asy. Approaches			hygiene for dependent resider	nts	
		vas not limited to, assist			with incontinence and the		
					importance of thoroughly		
		pileting and peri care			cleansing the skin of urine. He	ow	
	atter each inco	ontinent episode.			the corrective actions will be		
					monitored to ensure the deficie	ent	
					practice will not recur, ie., wha		
					quality assurance program wil	l be	
					put into place? *The DNS will		
					audit that dependent residents		
					have received proper persona	l	
					hygiene during regular room		
					rounds and observation of		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/28/2012
	ROVIDER OR SUPPLIER		STREET 2 375 S 1	ADDRESS, CITY, STATE, ZIP CODE 11TH ST DN, IN 47842	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION
	and #3 took Refresident's room The CNAs tranbed utilizing a Aresident's slack waist band and the resident's the incontinence brurine. The CNAs was peri-area. The not to cleanse that been in coslacks.			incontinence care via the C skills validation for the next days. Any noncompliance vimmediately corrected. *To ensure compliance, the DNS/Designee is responsit the completion of Resident Rounds CQI tool weekly tin weeks, bi-monthly times 2 months, and then quarterly continued compliance is maintained for 2 consecutive quarters. The results of the audits will be reviewed by the committee overseen by the athreshold of 95% is not achieved, and action plansed developed to ensure compliance including possible disciplinate action up to termination.	30 will be Die for Care nes 4 until /e se he CQI ED. If will be iiance,

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	onstruction on	(X3) DATE COMPL		
ANDILAN	OI CORRECTION	155319		LDING	00	03/28/	
		100010	B. WIN		PPPPG CONT. CO	00/20/	
NAME OF P	ROVIDER OR SUPPLIER			375 S 1	ADDRESS, CITY, STATE, ZIP CODE		
CLINTON	I GARDENS				N, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		resident was at risk for		TAG	BEFFEERET		DATE
		s of incontinence and					
		ance with incontinence					
	-	d check every two					
	hours for incon	-					
		unchec.					
	Durina interviev	w of the Assistant					
	_	sing (ADON) on					
		p.m., the ADON					
		esident's skin that was					
	in contact with	urine should have					
	been cleansed.						
	3.1-38(a)(3)(A)						
	1						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155319	B. WIN			03/28/2	2012
			D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				1TH ST		
CLINITON	N GARDENS						
CLINTO	N GARDENS			CLINTC	DN, IN 47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=E	483.25(d) NO CATHETER, BLADDER Based on the resident who entindwelling cathet the resident's clir that catheterizati resident who is in receives approprious prevent urinar restore as much possible. Based on obse and interview, the provide timely smuch bladder of 4 of 16 residentiand G) reviewed with toileting, in were not being manner. Findings includ 1. On 3/15/12 B was sitting in unit hallway. Cowater pitchers. to CNA #3, "Pleater of the toilet." CNA minute." The Cowater pitchers. responded, "Pleater of the residential control of the toilet." CNA minute." The Cowater pitchers. responded, "Pleater of the residential control of the toilet." CNA minute." The Cowater pitchers.	sident's comprehensive facility must ensure that a sers the facility without an ser is not catheterized unless inical condition demonstrates on was necessary; and a incontinent of bladder riate treatment and services by tract infections and to normal bladder function as revation, record review the facility failed to services to restore as function as possible for its (Residents B, E,F, and requiring assistance in that the residents assisted in a timely e: at 2:30 p.m., Resident a wheelchair on the E ENA #3 was picking up The resident indicated the sea, I've got to go to A #3 indicated, "Just a ENA kept picking up	F03		No Catheter, Restore, Bladder is the practice of this facility to ensure that a resident who ent the facility who is incontinent of bladder receives appropriate treatment and services to restorate as much normal bladder functions will be accomplished for those residents found to have been affected by the deficient practice? *Resident's B, E, F and G were provided an observation of a 3 day voiding pattern to determine their typical voiding schedules. Results were updating the careplans and CNA pool tools for notification of any changes. *Bladder Assessment have been completed for Resident B, E, F, and G. *Licensed nursing staff have beinserviced by the SDC/Designer regarding bladder assessment and the process of a 3 day voiding pattern by 04/27/2012. *An inservice held by the DNS 04/12/12 and 04/17/12 for all	ters of ore on or and on ated ket onts een ee	04/27/2012

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPLI 03/28/2	ETED
		100010	B. WING			00/20/	-V 12
	OF PROVIDER OR SUPPLIE ON GARDENS	3		375 S 1	ADDRESS, CITY, STATE, ZIP CODE 1TH ST NN, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	was not preser indicated, "I tol to the bathroor me, now I'm we were observed CNAs #1 and # standing at a dwork and talkin At 2:50 p.m., Resident B bac indicated to CN wet and needs 2:55 p.m., CNA Resident B to the resident gobservation of right as long as #3 asked the rewrong?" The resident rewrong?" The repants, I hate the heavy urine od room. The CNAs transbed utilizing a resident's slack waist band and the resident's tincontinence burine.	the activity room. Staff at. Resident B d them I wanted to go n and they didn't take et. The resident's pants wet. At 2:45 p.m., d were on E unit esk looking at paper ag about assignments. At 8 was pushing at to the unit. The RN As # 1 and #3 "She's to be cleaned up." At s #1 and #3 took he resident's room. ave permission for care stating. "It's all at I get changed." CNA esident "Are you ok?" esponded "No." CNA esident "What is esident replied "Wet he feel of wet pants." A or was observed in the d down to the middle of highs. The resident's rief was heavy with			direct care staff to educate on proper toileting plans for reside and bladder assessments. How will you identify other residents having the potential be affected by the same defici practice and what corrective action will be taken? *All dependent residents have the potential to be affected. *All dependent residents will be reassessed for voiding pattern using the bladder assessment including a 3 day voiding pattern using the bladder assessment admitted to the facility will be assessed upon their admission *Nursing staff have been inserviced on bladder assessments and 3 day voiding pattern by the SDC/Designee 04/27/2012. *An inservice held the DNS on 04/12/12 and 04/17/12 for all direct care staff educate on proper toileting platfor residents and bladder assessments. What measur will be put into place or what systemic changes you will mal to ensure that the deficient practice does not recur? *Blad assessments are completed u admission, quarterly, and with significant. Assessments will reviewed during regular MDS schedules. *Three day voiding patterns will be reviewed by th IDT and resident's will placed a toileting plan based on the pattern review to ensure as mubladder function, as possible. *Care plans will be updated to	ents to ent s, en n. g by ff to ens res ke der pon be g e on	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDDIC	00	COMPLETED
		155319		LDING		03/28/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE	
					1TH ST	
CLINTO	N GARDENS			CLINIC	DN, IN 47842	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	B's son was sta	anding in the resident's			reflect current status. *License	ed
		•			nurse will monitor daily to ensi	ure
	doorway. The son indicated the				each toileting program is	
		ed to go bathroom, but			followed. *An inservice held by	,
		ısy. The son indicated			the DNS on 04/12/12 and	
	he had told the	e nurse and the nurse			04/17/12 for all direct care stat	
	had told the Cl	NAs. The son indicated			educate on proper toileting pla	ins
	this is not a go	od time because of			for residents and bladder	
	staff lunch brea				assessments. How the	
		the son indicated to			corrective actions will be	
					monitored to ensure the deficie	
	_	o ahead and go if you			practice will not recur, ie., wha	
	have to."				quality assurance program will put into place? *Nursing staff	i be
					have been inserviced on blade	ler l
	At 11:15 a.m.,	CNAs #1 and #2			assessments and 3 day voiding	
	transferred the	resident, utilizing a			pattern by the SDC/Designee	~
		om the wheelchair to			04/27/12. *An inservice held b	-
	•	incontinence brief was			the DNS on 04/12/12 and	,
		with a smear of feces.			04/17/12 for all direct care stat	ff to
					educate on Bladder Assessme	ents
	i ne resident u	rinated in the toilet.			and 3 day voiding pattern and	
					proper toileting plans. *To ensu	re
	On 3/26/12 at	12:53 p.m., Resident			compliance, the DNS/Designee is	
	B's clinical reco	ord was reviewed.			responsible for the completion of	
					Resident Care Rounds CQI tool	
	An admission of	date of 4/18/07 was			weekly times 4 weeks, bi-monthly	
	noted.				times 2 months, and then quarterly	
	noted.				until continued compliance is	
	A				maintained for 2 consecutive	
		sessment, dated			quarters. The results of these audits	i
	•	fied the resident as			will be reviewed by the CQI	
	requiring exten	sive assist of two			committee overseen by the ED. If a	
	persons for tra	nsfers and toilet use.			threshold of 95% is not achieved,	
					and action plan will be developed to	
	A bladder continence assessment.			ensure compliance, including		
	dated 2/27/12, indicated the resident				possible disciplinary action up to	
					termination.	
		incontinent. The				
	section of the a	assessment titled				
	l "Comprehension	on of toileting needs"				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED	
		155319	B. WIN			03/28/2012	
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			1TH ST		
CLINTON	N GARDENS				DN, IN 47842		
	OARDENO			OLINIC	714, 114 47 042		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		of, but not limited to,					
	"Can the reside	ent comprehend and					
	follow simple ir	nstruction?" and "Can					
	the resident ide	entify the urge to					
	urinate?," was	not filled out. The					
	section of the a	assessment titled					
		Bladder assessment"					
		of "Is the resident					
	•	hysically aware of the					
		nd be able to use the					
		e, urinal, or bedpan?"					
	was not answe						
	was not answe	ried.					
	A plan of care	was noted with a					
	1 .	was noted, with a					
	l '	late of 10/22/11,					
		"Resident is at risk of					
		s of incontinence, over					
		', with approaches of					
	but not limited	to, of assist with					
	incontinent car	e and check every two					
	hours for incon	itinence. An approach					
	to toilet the res	ident was lacking.					
		5					
	2. Durina inter	view of Resident E on					
	_	m., the resident					
	indicated,	,					
	· '	two months. Fell at					
		ke my back. At first I					
	_	off felt I was going to					
		oo much. The call light					
	takes a long time to answer. The staff						
	will come in and tell you they will be						
		they don't return. Yes,					
	I've had accide	ents waiting for the staff					

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Event ID: 8WKN11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 03/28/	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	00/20/	2012
	N GARDENS			375 S 1 CLINTC	1TH ST DN, IN 47842		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION
IAU	to take me to the drink as much go to the bathromy tea and connight I just take. Resident E's clareviewed on 3/2. An admission of of,1/9/12, with limited to, Lumfracture after facture after factur	ne bathroom. Don't now, so don't have to com as much. I cut out fee and if I'm thirsty at small sips of water." inical record was 27/12 at 2:03 p.m. date was noted a diagnosis of, but not compound till. Ing Admission was noted, dated mentation was noted esident was "Continent sion." Intinence Assessment" I with Resident B's m lacked a date and		TAG			DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 03/28	LETED	
	PROVIDER OR SUPPLIER		B. WIN	375 S 1	ADDRESS, CITY, STATE, ZIP CODE 1TH ST NN, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
IAU	known, needs a daily living, inco assist with toile CAAs did not in urinary incontinurinary interview. The Coordinator on the Coordinator on the Coordinator on the Coordinator on the assessment staff person incontinurinary incontinurinary incontinurinary incontinurinary incontinurinary incontinurinary incontinurinary incontinurinary incontinurinary incontinuity in	assist with activities of ontinent and needs sting/pericare. The adicate the cause of tence. dated 2/1/12, dent is at risk of sof needs assist with re," An approach of ontinent care was broach to indicate a as lacking. w of the MDS 3/27/12 at 3:15 p.m., r indicated she fills out at for continence. The dicated she gets her incerning urinary in the ADL (activities of ord the CNAs fill out, the number of times incontinent of urine. On indicated the of interviewed		IAU			DATE
	3/16/12 at 2:30 indicated she w	view of Resident F, on p.m., the resident vas having incontinent o waiting too long for					

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PRINTED: 04/24/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CLINTON GARDENS NEGLET ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 STREET ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STREET ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STREET ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON AT 47842 ID REGION OF STATE ADDRESS. CITY, STATE, ZIP CODE ADDRESS AND SHOULD ADDRESS ADDRESS AND SHOULD ADDRESS CASH DEAL CASH DEAL CASH SHOULD ADDRESS AND SHOULD ADDRESS CASH DEAL CASH SHOULD CASH	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
NAME OF PROVIDER OR SUPPLIER CLINTON GARDENS (NATIDEDIC CONTROL OF DEPOCEMENTS CLINTON, IN 47842 (NATIDEDIC CONTROL OF DEPOCEMENTS CLINTON, IN 47842 (NATIDEDIC CONTROL OF DEPOCEMENTS CLINTON, IN 47842 (NATIDEDIC CONTROL OF DEPOCEMENTS CLINTON) IN 47842 (NATIDEDIC CONTROL OF DEPOCEMENTS CLINTONS CONTROL OF THE ARCH OF							1	
CLINTON GARDENS CIATION, IN 47842 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL TAG (EACH MUST MUST MUST MUST MUST MUST MUST MUST				b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident F's clinical record was reviewed on 3/28/12 at 9:30 a.m. A quarterly MDS, dated 2/28/12, indicated the resident was without cognitive problems, required extensive assist with transfers and tollet use, and was frequently incontinent of urine. An annual MDS, dated 12/09/11, indicated the resident was without cognitive problems, required extensive assist with transfers and tollet use and was frequently incontinent. The CAAs documented "Resident has accidents with urinary incontinent. The CAAs documented "Resident has accident] and decreased mobility. She is alert and toilets with assist of one staff. No specific time or program in place currently, resident will alert staff when she needs to go for the most part." Review of the ADL sheets for February and March 2011, documentation indicated the resident was continent at times. A bladder continence assessment,								
Resident F's clinical record was reviewed on 3/28/12 at 9:30 a.m. A quarterly MDS, dated 2/28/12, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use, and was frequently incontinent of urine. An annual MDS, dated 12/09/11, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use and was frequently incontinent. The CAAs documented "Resident has accidently and decreased mobility. She is alert and toilets with assist of one staff. No specific time or program in place currently, resident will allert staff when she needs to go for the most part." Review of the ADL sheets for February and March 2011, documentation indicated the resident was continent at times. A bladder continence assessment,	CLINTON	N GARDENS			CLINTC	N, IN 47842		
Resident F's clinical record was reviewed on 3/28/12 at 9:30 a.m. A quarterly MDS, dated 2/28/12, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use, and was frequently incontinent of urine. An annual MDS, dated 12/09/11, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use and was frequently incontinent. The CAAs documented "Resident has accidents with urinary incontinent. The CAAs documented "Resident has accidents with urinary incontinence secondary to her CVA [cerebral vascular accident] and decreased mobility. She is alert and toilets with assist of one staff. No specific time or program in place currently, resident will alert staff when she needs to go for the most part." Review of the ADL sheets for February and March 2011, documentation indicated the resident was continent at times. A bladder continence assessment,						PROVIDER'S PLAN OF CORRECTION		
reviewed on 3/28/12 at 9:30 a.m. A quarterly MDS, dated 2/28/12, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use, and was frequently incontinent of urine. An annual MDS, dated 12/09/11, indicated the resident was without cognitive problems, required extensive assist with transfers and toilet use and was frequently incontinent. The CAAs documented "Resident has accidents with urinary incontinence secondary to her CVA [cerebral vascular accident] and decreased mobility. She is alert and toilets with assist of one staff. No specific time or program in place currently, resident will alert staff when she needs to go for the most part." Review of the ADL sheets for February and March 2011, documentation indicated the resident was continent at times and incontinent at times. A bladder continence assessment,		·				CROSS-REFERENCED TO THE APPROPRIA	TE	
dated 2/27/12, indicated the resident was frequently incontinent. The	IAU	Resident F's clireviewed on 3/3 A quarterly MD indicated the recognitive proble extensive assist toilet use, and vincontinent of undicated the recognitive proble extensive assist toilet use and vincontinent. The "Resident has a incontinence set [cerebral vascudecreased most toilets with assist specific time or currently, resides the needs to get Review of the AFebruary and Mocumentation was continent at the A bladder contidated 2/27/12,	inical record was 28/12 at 9:30 a.m. S, dated 2/28/12, esident was without ems, required at with transfers and was frequently urine. S, dated 12/09/11, esident was without ems, required at with transfers and was frequently he CAAs documented accidents with urinary econdary to her CVA alar accident] and bility. She is alert and est of one staff. No a program in place ent will alert staff when to for the most part." ADL sheets for March 2011, indicated the resident est times and emes. Inence assessment, indicated the resident entire indicated		IAU			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155319	B. WIN			03/28/2012
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIER			375 S 1	1TH ST	
CLINTON	N GARDENS			CLINTC	N, IN 47842	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		assessment titled				
	•	on of toileting needs"				
	with questions of, but not limited to,					
		ent comprehend and				
	follow simple in	struction?" and "Can				
		entify the urge to				
		not filled out. Page 2				
	of the assessm	ent was missing				
	During interviev	w of the MDS				
		3/28/12 at 9:33 a.m.,				
		·				
		r indicated, "When I ment I didn't realize				
		cond page until after I				
		ner assessment for				
	another resider					
		dicated the second				
	l · •	sessment included				
	information tha	•				
		ne bladder assessment				
	•	of, but not limited to,				
		ether the resident				
		ally and physically				
		eed to void and be able				
		t, commode, urinal, or				
	bedpan					
		dinator indicated that				
	part of the asse	essment had not been				
	done.					
	4. On 3/16/12	at 11:00 a m				
		s observed to have her				
	call light turned					
		call light, turned the				
	I light off and inc	dicated to the resident				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		A. BUILDING 00			COMPLETED 03/28/2012			
		199919	B. WIN			03/20/	2012	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
CLINTON	I GARDENS		375 S 11TH ST CLINTON, IN 47842					
(X4) ID	SUMMARY ST	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	_	CNA #1 to help her.						
		cated one of the CNAs						
	_	unit was on lunch and						
		dents get backed up						
	on toileting.							
	On 3/16/12 of 1	1:15 a.m. tho						
	On 3/16/12 at 1 resident was in	•						
		e call light on and						
	•	eeded assistance to						
		a.m., CNA #2 entered						
		sked the resident what						
		he resident responded						
		ited the room. CNA #1						
		m right after CNA #2						
		started to take the						
		wheelchair to the						
		t this time, CNA #1						
	_	ne resident needed to						
	use the bathroo	om. CNA #1 indicated						
	she would have	e to get another CNA						
		exited the room. CNA						
	•	d indicated to the						
	resident she wo	ould return as soon as						
	she was done o	delivering condiments						
	to other resider	nts on the unit having						
	lunch in their ro	oms.						
	On 3/16/12 at 1	1:45 a.m., CNAs #1						
	and #2 returned	d to the resident's						
	room with a me	chanical lift. The						
	resident was tra	ansferred to the bed,						
	placed on a bed	dpan and was						
	observed to have	ve been incontinent of						
	bowel.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL		
		155319	A. BUII B. WIN	LDING		03/28/	
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			375 S 1			
CLINTON	N GARDENS			CLINTO	N, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110	TEGOETTONT ON	250 132.(111 111.(0 11.11 011.1111101.()		1110			
	During the inte	rview of the resident on					
	_	5 a.m., the resident					
		times she has to wait					
	over an hour ar						
		toileting. The resident					
	,	needed more help and new she has been on					
		much at times.					
	Resident G's cl	inical record was					
		26/12 at 1:41 p.m. The					
		Set [MDS] with					
	assessment ref						
	•	the resident with itive impairment, no					
	toileting plan, a	-					
	<u> </u>	owel and bladder.					
		Care Sheet, dated					
	-	ed, but was not limited					
	•	chanical lift with wo for transfers. Assist					
		ties of daily living,					
		m of T-time [i.e. upon					
		nd after meals, at hour					
	_	n] and pull ups.					
	-	g relates to Complaint					
	#IN00105028						
	3.1-41(a)(2)						
	0.1- 4 1(α)(Δ)						

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Facility ID: 000212

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PRINTED: 04/24/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155319	A. BUILDING B. WING	00	COMPLETED 03/28/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			

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Event ID: 8WKN11

Facility ID: 000212

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155319			03/28/2012	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER					
OL INITON	LOADDENO			11TH ST		
CLINTON	N GARDENS		CLINIC	ON, IN 47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	483.30(a) SUFFICIENT 24: CARE PLANS The facility must to provide nursin attain or maintair physical, mental, of each resident, assessments and The facility must sufficient number types of personn provide nursing of accordance with Except when wait this section, licer nursing personne Except when wait this section, the filicensed nurse to each tour of duty Based on obse and interview, to	have sufficient nursing staff g and related services to a the highest practicable and psychosocial well-being as determined by resident d individual plans of care. provide services by resident of the following lel on a 24-hour basis to care to all residents in resident care plans: ived under paragraph (c) of facility must designate a provide a charge nurse on		Sufficient 24 Hr Nursing Staff processor Care Plans It is the practice of this facility to have sufficient nursing staff to provide nursing and related services to attain of the processor care and related services to attain of the provide nursing and related services to attain of the provide nursing and related services to attain of the provide nursing and related services to attain the provide nursing attains the provide nursing and related services to attain the provide nursing attains	DATE DATE DATE	
	of daily living, for identified requir toileting/dressing were not provide	s' choices for activities or 8 of 16 residents ring assistance with ng, in that residents led the services in a Residents A, B, C, E,		maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. What corrective actions will be accomplished for those resident found to have been affected by the deficient practice? This fact employs sufficient staffing to provide nursing and related services. However, it has com	nts y sility	
				25. Tieses. Tiewever, it has com		

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Event ID: 8WKN11

Facility ID: 000212

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155319	B. WIN			03/28/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L			1TH ST	
CLINTON	I GARDENS				DN, IN 47842	
			_	l	714, 114 47 042	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
		at 2:30 p.m., Resident			to our attention that our nursin	g
		a wheelchair on the E			staff need educated for time management skills and priority	of
	unit hallway. CNA #3 was picking up water pitchers. The resident indicated				performed job duties. *An	Oi
					inservice was held by the DNS	on
	to CNA #3, "Ple	ease, I've got to go to			04/12/12 and 04/17/12 for all	
	the toilet." CNA #3 indicated, "Just a				direct care staff to educate	
		NA kept picking up			resident assistance in a timely	
	water pitchers.				manner to prevent incontinend	
	•	ease, oh come on			and/or honor resident choices	TOF
	•	p.m., CNA # 1 pushed			ADL care in a timely manner. *Resident A, B, C, E, F, G, H a	and
	· ·	·			I were included in the overall	
		the activity room. Staff			reassessment of a 3 day voidi	ng
	was not preser				pattern to determine their typic	_
		d them I wanted to go			voiding schedules. Results we	re
		n and they didn't take			updated in the careplans and	
		et." The resident's			CNA pocket tools for notification	on
	•	served wet. At 2:45			of any changes. How will you identify other residents having	the
	p.m., CNAs #1	and #3 were on E unit			potential to be affected by the	uie
	standing at a d	esk looking at paper			same deficient practice and wh	nat
	work and talkin	g about assignments.			corrective action will be taken?	
	At 2:50 p.m., R	N #5 was pushing			*All residents have the potentia	•
	Resident B bad	k to the unit. The RN			be affected. *All residents wil	l be
	indicated to CN	IAs # 1 and #3 "She's			assessed for voiding patterns	
		to be cleaned up." At			using the bladder assessment including a 3 day voiding patte	•
		As #1 and #3 took			assessment. Any newly admit	
		he resident's room.			resident will be assessed upor	
		ave permission for			admission.*Nursing staff have	
	_				been reeducated on following	
		care indicating, "It's all			resident's plan of care while us	sing
		s I get changed." CNA			time management skills and	
		esident "Are you ok?"			properly prioritizing job duties.	tha
		sponded "No." CNA			Any changes will be noted on the CNA pocket tool and the resident	•
		esident "What is			care plan updated.What	OI IL
	wrong?" The r	esident replied, "Wet			measures will be put into place	e or
	pants, I hate th	e feel of wet pants."			what systemic changes you wi	•
	A heavy urine of	odor was observed in			make to ensure that the deficie	
	the room.				practice does not recur?*CNA'	s
			1			

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Event ID: 8WKN11

Facility ID: 000212

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE : COMPL		
		155319		LDING		03/28/	
			B. WIN		ADDRESS SYTY STATE SID SODE	00/20/	
NAME OF PI	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLINTON	GARDENS				1TH ST DN, IN 47842		
				CLINIC	711, 111 47 642		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	0.04040.4				have been provided with properties to be the have been provided with properties.		
		10:50 a.m., Resident			residents and time manageme		
		anding in the resident's			skills. All updates will be place		
	•	son indicated the			on the CNA pocket tool for		
		d to go bathroom, but			resident care. In addition,		
		ousy. The son indicated			resident care plans will be		
	he had told the	nurse and the nurse			updated upon admission, readmission, annually, quarter	·lv	
	had told the CN	IAs. The son indicated			and upon significant	ıy,	
	this is not a goo	od time because of			change.*CNA working schedu	les	
	staff lunch brea	aks. At 11:00 a.m., the			have also been adjusted to ad		
	son indicated to	the resident "Go			one staff member to split their		
	ahead and go i	f you have to."			time between day shift and		
	J	,			evening shift to provide more		
	During interviev	w of CNA # 1 on			coverage for timely incontinen care during high traffic times of		
	-	5 a.m., the CNA			the day. How the corrective		
		erning assignments,			actions will be monitored to		
		the resident's are the			ensure the deficient practice w	/ill	
	ones that pay."				not recur, ie., what quality		
	ones that pay.				assurance program will be put		
	2 During inter	view of Booldont E on			into place?*The DNS/Designe shall perform random	е	
		view of Resident E on			audits/facility rounds to monito	or	
	•	m., the resident			resident assistance with		
		been here two months.			toileting/dressing and proper		
		nd broke my back. At			personal hygiene standards.		
	•	ne staff felt I was going			Resident's will also be		
		n too much. The call			interviewed using the CQI Resident Interview to ensure		
	•	ng time to answer. The			compliance.*Licensed nurses	will	
		in and tell you they will			monitor call light response tim		
		en they don't return.			and provision of care to ensur	е	
		ccidents waiting for the			timely incontinence care.*Staf	f	
		e to the bathroom.			found to not answer call lights		
	Don't drink as much now, so don't				promptly and/or not provide ca promptly will be addressed	ие	
	have to go to the	ne bathroom as much.			immediately.*To ensure		
	I cut out my tea and coffee and if I'm				compliance, the DNS/Designee is		
	thirsty at night	l just take small sips of			responsible for the completion of		
	water."	•			Resident Care Rounds CQI tool		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE S COMPL		
THEFTERN	or condition	155319		LDING		03/28/	
			B. WIN	_	ADDRESS CITY STATE 7ID CODE	53,23,	· -
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 1TH ST		
CLINTON	N GARDENS				DN, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	An admission Masel assessment indicated the resincentinent of the extensive assist transfers. The indicated the resident was all confusion, able known, needs a daily living, incompassist with toile CAAs did not in urinary incontinuinary incontinu	MDS [Minimum Data nt, dated 1/22/12, esident was frequently urine and required stance of two with assessment also esident was without ems. The CAAs (care ent) documented the ert with occasional to make needs assist with activities of ontinent and needs sting/pericare. The ndicate the cause of mence. View of Resident F on p.m., the resident was having incontinent to waiting too long for example 128/12 at 9:30 a.m. S, dated 2/28/12, esident was without ems, required at with transfers and was frequently			weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, and action plan will be developed to ensure compliance, including possible disciplinary action up to termination.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155319	B. WIN	IG		03/28/2	2012
NAME OF F	DROVADED OD GLIDDI IED		_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	C.		375 S 1	1TH ST		
CLINTON	N GARDENS			CLINTO	N, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	1	view of Resident A on					
		p.m., the resident					
	indicated "Yes, I have accidents						
	_	staff to come. They					
	•	hey are very nice to me					
	and help me ge	et cleaned up."					
	Resident A's cl	inical record was					
	reviewed on 3/	17/12 at 1:54 p.m.					
		date was noted of					
	1/9/12.						
	An admission N	MDS, dated 1/16/12,					
		esident as having					
		•					
	1	itive impairment,					
		sive assistance of two					
	with transfers a	• •					
		pladder. The CAAs					
	documented th						
		a fall resulting in a left					
	hip fracture. W						
		nfusion, had been					
		Foley catheter, but					
		ved, receives diuretics					
	and uses a bed	lpan at night.					
	A bladder conti	inence assessment,					
		indicated the resident					
	was "Always C						
	•	dated 3/26/12 at 2:35					
		the resident was					
	continent of bo	wel and bladder,					
	toileted per sta	ff, and had occasional					

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Event ID: 8WKN11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155319	B. WIN			03/28/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CLINTO	N GARDENS			375 S 1	11H S1 DN, IN 47842		
				<u> </u>	7N, IN 47042		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	urinary incontir	, , , , , , , , , , , , , , , , , , ,		1110			DATE
		ichico.					
	IPN (Interdiscir	olinary Progress					
		2/14/12 at 9 a.m.,					
	· ·	Jp in wheelchair more					
	oftenCont of B &B."						
	5. On 3/27/12	at 9:40 a.m., Resident					
		ed in bed. The ADON					
	(Assistant Dire	ctor of Nursing) took a					
		m under the resident.					
	Three incontinence pads were						
	noticed under t	•					
	The resident in	idicated "When I have					
	to go, I have to	go. I feel so bad for					
	the girls when	I can't hold it. They					
	work so hard a	nd then they have to					
	change my bed	d."					
	During intervie	w of Resident C on					
		m., the resident					
	indicated she h	nas had accidents					
	_	bedpan, but if the girls					
		meone else they can't					
	help it.						
		linical record was					
		28/12 at 10:00 a.m. A					
	Minimum Data						
		ompleted on 3/3/12,					
		dent with no cognitive					
	•	quired extensive					
		wo for toileting and was					
	frequently inco	ntinent of urine.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
1111212111	or condition,	155319		LDING		03/28/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			375 S 1			
CLINTO	N GARDENS			CLINTO	N, IN 47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	6 During inter	view with the Assistant					
		sing on 3/27/12 at 9:30					
		N indicated if night shift					
		ne of the resident's up					
	on their shift, it	s hard for the day shift					
	to get everythir	ng done.					
	1	view of Resident H on					
		p.m., the resident					
		elt that sometimes					
		enough staff to help					
		ent indicated the staff light, turn it off and					
		ong coming back to					
	take her to the						
		ted she has had					
		ng too long and has					
		han a half hour. The					
	resident stated	a nurse said "We work					
	with what we h	ave." The resident					
	also indicated	she has to wait longer					
	_	nd that the wait was					
	recent.						
	Deview of the	clinical record of					
		3/27/12 at 2 p.m.,					
		ost recent Minimum					
		s) assessment was					
	,	6/12. The assessment					
		esident with moderate					
		cognitive decision					
	making skills, e	extensive assistance					
	with toileting, a	nd frequent					
	incontinence of	furine. The Activity of					

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Event ID: 8WKN11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
155319			A. BUILDING B. WING			03/28/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				375 S 1			
CLINTON	N GARDENS				DN, IN 47842		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		rm for March 2012		IAG	Dia lettike 1		DATE
	, ,	esident was continent					
		it for bladder function.					
		it for bladder furfetion.					
	The current pla	an of care addressed					
	the problem of	the resident required					
	the FIT toileting	g program, dated					
	6/28/11, with a	pproaches that					
		ere not limited to toilet					
	upon rising, before and after meals, at bed time, and change at night as						
	needed.						
	Interview of CN	NΔ #10 on 3/28/12 at					
	Interview of CNA #10 on 3/28/12 at 12:05 p.m., indicated Resident H was only occasionally incontinent.						
		any moontanona.					
	8. Interview of	Resident I on 3/15/12					
	at 3:40 p.m., indicated he has had accidents with bowels waiting too long for staff to assist. The resident indicated the staff go and help others						
		Ip him. Review of the					
		of Resident I on					
		5 p.m., indicated the					
		inimum Data Set					
		ment was completed sessment identified the					
	resident as independent in cognitive decision making skills and continent of bowel and bladder.						
	9. On 3/16/12						
		as observed to have her					
	call light turned						
	_	call light, turned the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	COMPLETED			
155319			B. WING 03/28/2012				
NAME OF B	DOWIDED OD SLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				375 S 1	1TH ST		
CLINTON	N GARDENS			CLINTO	N, IN 47842		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	•	dicated to the resident					
	she would get	CNA #1 to help her.					
	The nurse indic	cated one of the CNAs					
	assigned to the	unit was on lunch and					
	sometimes resi	idents get backed up					
	on toileting.						
	_						
	On 3/16/12 at 1	11:15 a.m., the					
	resident was in	terviewed. The					
	resident put the	e call light on and					
	indicated she needed assistance to toilet. At 11:43 a.m., CNA #2 entered the room and asked the resident what she needed. The resident responded and CNA #2 exited the room. CNA						
	#1 entered the room right after CNA #2 had exited and started to take the resident in the wheelchair to the						
	dining room. At this time CNA#1 was informed, the resident needed to use the bathroom. CNA #1 indicated she						
	would have to get another CNA to help her and exited the room. CNA #2						
	returned and indicated to the resident she would return as soon as she was done delivering condiments to other						
		e unit having lunch in					
	their rooms.						
	On 2/16/12 at 1	11:45 a.m. CNA a.#4					
		11:45 a.m., CNAs #1					
	and #2 returned to the resident's						
		echanical lift. The					
		ansferred to the bed,					
	placed on a be	•					
	observed to ha	ve been incontinent of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
155319			A. BUILDING			03/28/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			1TH ST		
CLINTON GARDENS					DN, IN 47842		
	OARDENO		GENVION, IN 47042				
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	<u> </u>	DATE
	bowel.						
	During the inte	rview of the resident on					
	3/16/12 at 11:1	5 a.m., the resident					
		etimes she has to wait					
	over an hour a						
		n toileting. The resident					
		needed more help and					
	•	knew she has been on					
	the call light too much at times.						
	Resident G's clinical record was						
	reviewed on 3/26/12 at 1:41 p.m. The Minimum Data Set [MDS] with assessment reference date of 1/10/12, coded the resident with moderate cognitive impairment. no						
	toileting plan, a	•					
	• •						
	incontinent of bowel and bladder, required extensive assistance of two for transfers and toileting. The Resident Care Sheet, dated 3/27/12, included, but was not limited to, requires mechanical lift with assistance of two the toileting program of T-time [i.e. upon rising, before and after meals, at hour of						
	sleep and prn].						
	10 Review of	the nursing schedule					
	Review of the nursing schedule indicated four licensed nurses and six						
		utinely scheduled to					
provide care for 76 residents on the							
	day shift. Four	nurses and six CNAs					

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		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
and Plan of Correction identification number: 155319		A. BUILDING 00		03/28/2012					
		.00010	B. WIN		DDDECC CITY CTATE 7ID CODE	30,20,			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE				
	N GARDENS		375 S 11TH ST CLINTON, IN 47842						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE		
1710		d for evening shift and		1710			BITTE		
		nd four CNAs for night							
	shift.	ia ioar ora to ior inglic							
	Dovious of the	Census and Condition							
		that 56 residents							
	-	ance of one or two for							
	•	quired assist of one or							
	_	s and 56 required							
		ne or two for toilet use.							
		ents were identified as							
	occasionally or frequently incontinent								
	of bladder. This federal tag relates to Complaint								
	#IN00105028								
	3.1-17(a)								

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319		A. BUILDING B. WING		COMP	COMPLETED 03/28/2012				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST						
CLINTON	I GARDENS			DN, IN 47842					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			

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